MC-7078

Patient Name	**: Ms. NEHA**	Specimen Drawn ON	: 14/Jan/2026 10:00AM
Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 05:21PM
Barcode No	**: C6255867**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
Ref Customer	: SELF	Client Name	: AVERT LABORATORIES

DEPARTMENT OF HAEMATOLOGY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HbA1c (ngsp)	5.4	%	Non diabetic adults >=18 years <5.7~At risk (Prediabetes) 5.7 - 6.4~Diagnosing Diabetes >= 6.5	HPLC
HbA1c (IFCC)	35.43	mmol/mol		HPLC
Estimated Average Glucose	108.3	mg/dl		Calculated

Interpretation:

As per American Diabetes Association (ADA)	
Reference Group	**HbA1c in %**
Non diabetic adults >=18 years	**<5.7**
At risk (Prediabetes)	**5.7 – 6.4**
Diagnosing Diabetes	**>=6.5**

Note:

1, Since HbA1c reflects long term fluctuation in the blood glucose concentration , a diabetic patient who is recently under good control may still have a high concentration of HbA1c . Converse is true for a diabetic previously under good control but now proply controlled.

2, Target goals of <7.0% may be beneficial in patients with short duration of diabetes , long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes ,limit life expectancy or extensive co-morbid conditions, targeting a goal of <7.0 % may not be appropriate.

Comment :

HBA1c provides an index of average blood glucose levels over the past 8 – 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

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MC-7078

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Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 05:21PM
Barcode No	**: C6255867**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
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DEPARTMENT OF HAEMATOLOGY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method

Bio-Rad CDM System
VII TURBO #1. SN-16477

PATIENT REPORT
V2TURBO_A1c_2.0

Patient Data

Sample ID: C6255867
Patient ID:
Name:
Physician:
Sex:
DOB:

Comments:

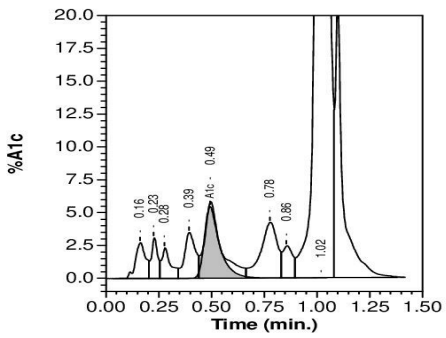
Analysis Data

Analysis Performed: 01/14/2026 17:16:54
Injection Number: 5516
Run Number: 70
Rack ID:
Tube Number: 7
Report Generated: 01/14/2026 17:18:26
Operator ID:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.5	0.160	20077
A1b	---	1.0	0.226	13999
F	---	1.1	0.277	14743
LA1c	---	2.0	0.394	27598
A1c	5.4	---	0.493	60353
P3	---	3.7	0.776	50791
P4	---	1.3	0.856	17533
Ao	---	85.0	1.021	1158259

Total Area: 1,363,353

HbA1c (NGSP) = 5.4 %



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LAB HEAD	SR. CONSULTANT PATHOLOGIST	CONSULTANT PATHOLOGIST	SR. CONSULTANT PATHOLOGIST
REGD NO. 21087	REGD. NO. 5015	REGD NO. 83525	REGD. NO. 4268

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MC-7078

Patient Name	**: Ms. NEHA**	Specimen Drawn ON	: 14/Jan/2026 10:00AM
Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 04:48PM
Barcode No	**: C6255867**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
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DEPARTMENT OF HAEMATOLOGY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT(CBC)23				
R.B.C	4.59	Millions/cumm	4.5-5.5	Impedance variation
Haemoglobin	13.1	g/dl	12.0-15.0	Spectrophotometry
Packed Cell Volume	**39.90**	%	40.0-50.0	Analogical Integration
MCV	86.93	fL	80-100	
MCH	28.54	pg	27.0-32.0	Calculated
MCHC	32.83	g/dL	27.0-48.0	Calculated
RDW-CV	13.6	%	11.5-14.0	Calculated
Platelet Count	377	x1000/uL	150-450	Impedance Variation
Total WBC Count	8200	/cumm	4000-10000	Impedance Variation
TNC	8.20			
MPV	**8.80**	%	9.1-11.9	Calculated
PCT	0.33	%	0.18-0.39	Calculated
PDW	**16.60**	%	9.0-15.0	Calculated
Differential Leucocyte Count				
Neutrophil	60	%	40.0-80.0	flow cytometry/manual
Lymphocyte	30	%	20.0-40.0	flow cytometry/manual
Monocytes	09	%	2-10	flow cytometry/manual
Eosinophils	01	%	01-06	Flow cytometry/manual
Basophils	00	%	0-2	Flow cytometry/manual
Absolute Neutrophils	4.92	1000/uL	2.00-7.00	
Absolute Lymphocytes	2.46	1000/µL	1.00-3.00	
Absolute Monocytes	0.74	1000/µL	0.20-1.00	
Absolute Eosinophils	0.08	1000/µL	0.02-0.50	
Neutrophil-Lymphocyte Ratio	2.00			Calculated
Lymphocyte-Monocyte Ratio	3			Calculated
Platelet-Lymphocyte Ratio	13			Calculated

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MC-7078

Patient Name	**: Ms. NEHA**	Specimen Drawn ON	: 14/Jan/2026 10:00AM
Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 04:49PM
Barcode No	**: C6255867**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
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DEPARTMENT OF HAEMATOLOGY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
Erythrocyte Sedimentation Rate (ESR)	16	mm/h	0-20	Westergren

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Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 05:28PM
Barcode No	**: C6255865**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
Ref Customer	: SELF	Client Name	: AVERT LABORATORIES

DEPARTMENT OF BIOCHEMISTRY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE FASTING				
Sample Type : Sod.Fluoride - F				
Glucose Fasting	88.4	mg/dl	70.0 - 110.0	GOD-POD

Interpretation (In accordance with the American diabetes association guidelines):

· A fasting plasma glucose level below 110 mg/dL is considered normal.

· A fasting plasma glucose level between 100-126 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients.

· A fasting plasma glucose level of above 126 mg/dL is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dL on both the occasions is confirmatory of a diabetic state.

EGFR (ESTIMATED GLOMERULAR FILTRATION RATE)				
Creatinine	0.61	mg/dL	0.60-1.20	Jaffe Kinetic
Blood Urea Nitrogen (BUN)	14.08	mg/dL	6-20	spectrophotometry
Albumin (Serum)	4.81	g/dL	3.5-5.5	Bromo Cresol Green (BCG)
EGFR By MDRD	118.15	mL/min/1.73 m2		Spectrophotometric - Calculated

COMMENT-The Kidney Disease Improving Global Outcomes (KDIGO) guideline defines CKD by the presence of glomerular filtration rate (GFR) <60 mL/min/1.73m2 for >3 months and/or evidence of kidney damage (eg, structural abnormalities, histologic abnormalities, albuminuria, urinary sediment abnormalities, renal tubular disorders, and/or history of kidney transplantation) for >3months.2 Thus, monitoring should include tests for GFR, albuminuria, and urine sediment.

CLINICAL USE-

• Detect chronic kidney disease (CKD) in adults.

• Monitor CKD therapy and/or progression in adults.

Interpretation of eGFR Values	
eGFR (mL/min/1.73m^2)	**Interpretation**
90	Normal
60-89	Mild decrease
45-59	Mild to moderate decrease
30-44	Moderate to severe decrease
15-29	Severe decrease
<15	Kidney failure

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DEPARTMENT OF BIOCHEMISTRY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST (LFT)-EXTENDED				
Sample Type : SERUM				
Bilirubin Total	0.94	mg/dl	<1.1	Diazotized Sulfanilic
Bilirubin Direct	0.25	mg/dl	0-0.3	Diazotized Sulfanilic
Bilirubin Indirect	0.69	mg/dl	0.30-1.00	Calculated
SGOT (AST)	**35.3**	U/L	<31.0	IFCC without pyridoxal phosphate
SGPT (ALT)	**39.0**	U/L	<33.0	IFCC without pyridoxal phosphate
Alkaline Phosphatase (ALP)	**135.7**	U/L	35-104	Spectrophotometry
Gamma Glutamyl Transferase (GGT)	12.9	U/L	05-40	L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate
Protein Total	7.4	g/dL	6.6-8.7	Biuret
Albumin (Serum)	4.81	g/dL	3.5-5.5	Bromo Cresol Green (BCG)
Globulin	2.59	g/dL	2.50-3.50	Calculated
A/G Ratio	1.86		1.5-2.5	Calculated

Interpretation:- Liver blood tests, or liver function tests, are used to detect and diagnose disease or inflammation of the liver. Elevated aminotransferase (ALT, AST) levels are measured as well as alkaline phosphatase, albumin, and bilirubin. Some diseases that cause abnormal levels of ALT and AST include hepatitis A, B, and C, cirrhosis, iron overload, and Tylenol liver damage. Medications also cause elevated liver enzymes. There are less common conditions and diseases that also cause elevated liver enzyme levels.: Liver blood tests, or liver function tests, are used to detect and diagnose disease or inflammation of the liver. Elevated aminotransferase (ALT, AST) levels are measured as well as alkaline phosphatase, albumin, and bilirubin. Some diseases that cause abnormal levels of ALT and AST include hepatitis A, B, and C, cirrhosis, iron overload, and Tylenol liver damage. Medications also cause elevated liver enzymes.There are less common conditions and diseases that also cause elevated liver enzyme levels.

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DEPARTMENT OF BIOCHEMISTRY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE BASIC				
Sample Type : SERUM				
Total Cholesterol	177.1	mg/dL	Desirable - 200, Borderline high - 200-239, High - ≥ 240	CHO-POD
Triglyceride	98.9	mg/dL	0.0-150 :Normal 151-199:Border Line >=200 :High 200.0-499.0 High ~> 500 Very High	GPO-POD
HDL Cholesterol	44.7	mg/dL	40-60	Direct (PVS/PEGME precipitation & Trinder reaction)
Non HDL Cholesterol	**132.40**	mg/dL	< 130 mg/dL	Calculated
VLDL Cholesterol	19.8	mg/dL	2.00-30.00	Calculated
LDL Cholesterol	112.62	mg/dL	0-130 :Normal~131-155:Borderline~>=160 :High	Direct (PVS/PEGME precipitation & Trinder reaction)
Cholesterol/HDL Ratio	3.96	Ratio	<4.00	Calculated
LDL / HDL Cholestrol Ratio	2.52	Ratio	<3.50	Calculated
HDL/LDL Cholesterol Ratio	0.40	Ratio	<3.50	Calculated

Cholesterol Level	**mg/dL**	
Desirable	200	
Borderline High	200 - 239	
High	≥ 240	
Risk Modifiers As per ASCVD		
PARAMETRS	**mg/dL**	
HDL	<40 - low	
	>60 - high	
LDL	<100 optimal	
TRIGLYCERIDE LEVELS	< 150 for fasting	
	< 175 for Non fasting	
Treatments Goal as per LAI 2023		
ASCVD RISK CATEGORY	**TREATMENT GOAL**	
	LDL-C in mg/dL Primary Target	**NonHDL-C in mg/dL CO-Primary Target**
LOW	<100	**<130**
MODERATE	<100	**<130**
HIGH	<70	**<100**
VERY HIGH	<50	**<80**
EXTREME (A)	<50 or <30	**<80 or <60**
EXTREME (B)	<30	**<60**

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DEPARTMENT OF BIOCHEMISTRY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
IRON PROFILE BASIC				
Iron, Serum	64	ug/dL	59-158	Colorimetric
Total Iron Binding Capacity-(TIBC)	327	ug/dL	250-400	Spectro-photometry
UIBC-SERUM	263.00	ug/dL	110-370	Direct Determination with Ferrozinc
Transferrin Saturation	19.57	%	16-50	Calculated

Total iron-binding capacity

The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood.

Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose

Transferrin Saturation

1g of transferrin can carry 1.43g of iron. Normally, iron saturation of transferrin (transferrin saturation) is between 10% and 50%. Because of its short half-life, transferrin values decrease more quickly in protein malnutrition states and should be taken into consideration while evaluating iron-deficiency states

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DEPARTMENT OF BIOCHEMISTRY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
Kidney Function Test EXTENDED				
Urea	30.13	mg/dL	18.0-45.0	Urease UV
Creatinine	0.61	mg/dL	0.60-1.20	Jaffe Kinetic
Calcium	9.0	mg/dL	8.6-10.2	NM-BAPTA
Uric Acid	3.03	mg/dl	2.30-6.60	Spectro-photometry
Phosphorus	2.7	mg/dL	2.50-5.00	Ammonium molybdate UV
Sodium (NA+)	140.00	mmol/L	135.0-145.0	Ion Selective Electrode
Potassium (K+)	4.46	mmol/L	3.50-5.50	Ion Selective Electrode
Chloride	103.00	mmol/L	98.0-109.0	Ion Selective Electrode
Blood Urea Nitrogen (BUN)	14.08	mg/dL	6-20	spectrophotometry
Bun / Creatinine Ratio	**23.08**	Ratio	0.0-23.0	Calculated
Urea / Creatinine Ratio	**49.39**	Ratio	20-35	Calculated

Interpretation:- Kidney blood tests, or Kidney function tests, are used to detect and diagnose disease of the Kidney.

The higher the blood levels of urea and creatinine, the less well the kidneys are working.
The level of creatinine is usually used as a marker as to the severity of kidney failure. (Creatinine in itself is not harmful, but a high level indicates that the kidneys are not working properly. So, many other waste products will not be cleared out of the bloodstream.) You normally need treatment with dialysis if the level of creatinine goes higher than a certain value.
Dehydration can also be a come for increases in urea level.
Before and after starting treatment with certain medicines. Some medicines occasionally cause kidney damage (Nephrotoxic Drug) as a side-effect. Therefore, kidney function is often checked before and after starting treatment with certain medicines.

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Ref Customer	: SELF	Client Name	: AVERT LABORATORIES

DEPARTMENT OF IMMUNOASSAY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE				
Sample Type : SERUM				
Triiodothyronine Total (T3)	1.24	ng/mL	0.70-2.04	Chemiluminescence Immunoassay (CLIA)
Thyroxine Total (T4)	8.90	ug/dL	4.6-10.5	Chemiluminescence Immunoassay (CLIA)
TSH (4th Generation)	2.331	uIU/mL	0.40-4.20	Chemiluminescence Immunoassay (CLIA)

PREGNANCY	REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association.)
1st Trimester	0.10-2.50 uIU/mL
2nd Trimester	0.20-3.00 uIU/mL
3rd Trimester	0.30-3.00 uIU/mL

INTERPRETATION-

1. Primary hyperthyroidism is accompanied by elevated serum T3 & T4 values along with depressed TSH level.
2 .Primary hypothyroidism is accompanied by depressed serum T3 and T4 values & elevated serum TSH levels.
3. Normal T4 levels accompanied by high T3 levels and low TSH are seen in patients with T3 thyrotoxicosis.
4. Normal or low T3 & high T4 levels indicate T4 thyrotoxicosis (problem is conversion of T4 to T3)
5. Normal T3 & T4 along with low TSH indicate mild / subclinical HYPERTHYROIDISM .
6. Normal T3 & low T4 along with high TSH is seen in HYPOTHYROIDISM .
7. Normal T3 & T4 levels with high TSH indicate Mild / Subclinical HYPOTHYROIDISM .
8. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
9. Although elevated TSH levels are nearly always indicative of primary hypothroidism . rarely they can result from TSH secreting pituitary tumours (seconday hyperthyroidism)

TSH IS DONE BY ULTRASENSITIVE 4th GENERATION CHEMIFLEX ASSAY

COMMENTS:

Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Note:

TSH levels may fluctuate based on few factors such as pregnancy, illness and age. Also, time of sample collection, technologies used to analyze the test, usage of certain drugs. Diet may have impact on TSH levels. TSH may show around 50% variation even when done at different times of day due to its association with circadian rhythm.

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UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 05:27PM
Barcode No	**: C6255865**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
Ref Customer	: SELF	Client Name	: AVERT LABORATORIES

DEPARTMENT OF IMMUNOASSAY

Test Name	Result	Unit	Bio. Ref. Range	Method
Prolactin	8.72	ng/ml	<50 years : 3.34-26.72~≥50 years: 2.74-19.64	Chemiluminescence Immunoassay (CLIA)

Reference range in
Pregnancy,3rd trimester -95.00 - 473.00 ng/ml
Post Menopausal 1.80 – 20.30 ng/ml

Comments:
1.Since prolactin is secreted in a pulsatile manner and is also influenced by a variety of physiologic stimuli, it is recommended to test 3 specimens
at20-30 minute intervals after pooling.
2.Major circulating form of Prolactin is a nonglycosylated monomer, but several forms of Prolactin linked with immunoglobulin occur which can give falsely high Prolactin results.
3.Macroprolactin assay is recommended if prolactin levels are elevated, but signs and symptoms of hyperprolactinemia are absent or pituitary imaging studies are normal

Clinical Use
·Diagnosis & management of pituitary adenomas
·Differential diagnosis of male & female hypogonadism

Increased Levels
Physiologic: Sleep, stress, postprandially, pain, coitus
Systemic disorders: Chest wall or thoracic spinal cord lesions, Primary / Secondary hypothyroidism, Adrenal insufficiency, Chronic renal failure, Cirrhosis
Medications: Psychiatric medications like Phenothiazine, Haloperidol,
Risperidone, Domperidone, Fluoexetine, Amitriptylene, MAO inhibitors etc.,
Antihypertensives: Alphamethyldopa, Reserpine, Verapamil,Opiates: Heroin, Methadone, Morphine,
Apomorphine,Cimetidine / Ranitidine
Prolactin secreting pituitary tumors: Prolactinoma, Acromegaly
Miscellaneous: Epileptic seizures, Ectopic secretion of prolactin by non-pituitary tumors,pressure / transaction of pituitary stalk, macroprolactinemia
Idiopathic

Decreased levels
·Pituitary deficiency: Pituitary necrosis / infarction
·Bromocriptine administration
·Pseudohypoparathyroidism

This report has been validated by:

DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

DR. ANIL GUPTA
M.B.B.S , M.D. (PATH)
SR. CONSULTANT PATHOLOGIST
REGD. NO. 5015

DR. NEERU AGARWAL
M.B.B.S , M.D. (PATH)
LAB HEAD
REGD NO. 21087

QR CODE

MC-7078

Patient Name	**: Ms. NEHA**	Specimen Drawn ON	: 14/Jan/2026 10:00AM
Age/Gender	: 36 YRS /F	Specimen Received ON	: 14/Jan/2026 04:35PM
UHID/MR No	: ADEL.0003975894	Report Date	: 14/Jan/2026 05:27PM
Barcode No	**: C6255865**	Client Code	: DL1360
Ref Doctor	: Dr.MANGLA PRAVEEN	Visit ID	: MDEL3978898
Ref Customer	: SELF	Client Name	: AVERT LABORATORIES

DEPARTMENT OF IMMUNOASSAY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12				
Sample Type : SERUM				
Vitamin B12 Level	**161.0**	pg/mL	211-911	Chemiluminescence Immunoassay(CLIA)

Comments

Vitamin B_{12} along with folate is essential for DNA synthesis and myelin formation. Vitamin B_{12} deficiency can be because of nutritional deficiency, malabsorption and other gastrointestinal causes. The test is ordered primarily to help diagnose the cause of macrocytic/ megaloblastic anemia.

Decreased levels are seen in:	Increased levels are seen in:
anaemia, normal near term pregnancy, vegetarianism, partial gastrectomy/ ileal damage, celiac disease, with oral contraceptive use, parasitic competition, pancreatic deficiency, treated epilepsy, smoking, hemodialysis and advancing age	renal failure, hepatocelluar disorders, myeloproliferative disorders and at times with excess supplementation of vitamins pills

This report has been validated by:

DR. PAWAN KUMAR
Phd. BIOCHEMISTRY
CONSULTANT BIOCHEMIST

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DEPARTMENT OF IMMUNOASSAY

CRL SWASTHYA CARE

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN D3 25-HYDROXY				
Sample Type : SERUM				
Vitamin D, 25 Hydroxy	**7.73**	ng/mL	Deficiency<20 Sufficiency:20-65 Intoxication:>70	Enhanced Chemiluminescence (Ultre Sensitive 4th Generation Chemiflex)

Lower-than-normal levels suggest a vitamin D deficiency. This condition can result from Lack of exposure to sunlight,Lack of adequate vitamin D in the diet, Liver and kidney diseases and Malabsorption. A vitamin D deficiency may lead to: *Low blood calcium levels (hypocalcaemia) *Thin or weak bones (rickets, osteoporosis and osteomalacia) *High levels of parathyroid hormone (secondary hyperparathyroidism) Total 25-hydroxyvitamin D (D2 + D3) is the correct measure of Vitamin D status.Higher-than-normal levels suggest excess vitamin D, a condition called hypervitaminosis D. It is usually caused by vitamin D in the form of doctor-prescribed dietary supplements. 95% of serum vitamin D is Vit D3. D2 is only received from supplements.

***** End Of Report *****

This report has been validated by:

Pawan Kumar

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